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PRIVATE HEALTH SECTOR DEVELOPMENT AND THE USE OF USAID CREDIT MECHANISMS IN KLATEN, CENTRAL JAVA

Final Report

U.S. Agency for International Development

Prepared for: USAID/Indonesia and G/EG/CIS

Prepared by: Coopers & Lybrand, LLP

Sponsored by: Private Enterprise Development Support Project III
Contract No. PCE-0026-Q-00-3031-00
Delivery Order No. 11
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I. PURPOSE OF THE REPORT

The Credit and Investment Staff of USAID's Center for Economic Growth requested that a Coopers & Lybrand team of consultants assist USAID/Jakarta in examining the potential for using credit mechanisms to promote private health sector development in Indonesia. The team focused specifically on the potential for using credit within the context of the Managed Care Pilot Project in Klaten, Central Java.

Initially, USAID indicated that the credit support could be in the form of a guarantee offered through USAID's Micro and Small Enterprise Development (MSED) Program or USAID's Enhanced Credit Authority (ECA). In subsequent discussions with USAID's Credit & Investment Staff and USAID/Jakarta, it was agreed that the uncertainty regarding the availability of ECA[1] would prevent consideration of ECA as a supporting credit mechanism in the near-term. The MSED Program, which supports the development of micro and small private sector business activities, was therefore the most viable immediate option. For this reason, most of the possible uses of USAID credit support discussed in this report focus on MSED rather than ECA.

II. OVERVIEW

Indonesia brings together the diversity of 200 million people and 250 languages across more than 13,000 islands that span 3,000 miles. During the last twenty-five years, the productive capacity of the nation generated an average annual growth rate of more than six percent, resulting in important achievements in the social sector. Among the achievements was the development of the physical infrastructure and trained manpower for health service delivery throughout the archipelago. By 1992 the public system included: 6,200 health centers with approximately 90,000 workers; 337 referral and 16 teaching hospitals with 78,000 workers; and other specialty hospitals with 10,000 workers. The public system continues to develop, albeit at a substantially slower pace. In addition, a vigorous private sector network has flourished alongside the public system, often staffed by the same personnel.

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[1] The Office of Management and Budget (OMB) approved US$10 million in credit subsidy for ECA, based on a program justification submitted by USAID in September 1994. Congress was expected to approve ECA for implementation during FY96 but, following intense federal budget negotiations, decided to delay consideration of ECA until FY97 at the earliest.

In contrast to the growth trends mentioned above, trends in health status measures have demonstrated some declines, stagnation and considerable variability among the 27 provinces. Substantial declines in mortality indicators were registered through the middle to late 1980s. While progress in some preventive aspects of health, such as modern family planning, has continued through the 1990s, maternal mortality risks and malnutrition among children remain high. Access to safe water and sanitation facilities by the poor continues to be a major concern. Urbanization and industrialization have increased the incidence and sequela of traffic and industrial accidents, especially for some categories of workers.

Paradoxically, utilization of health services in public facilities is currently far below capacity. Between 1987 and 1992, public health service utilization by the poor declined. A World Bank report, *Improving Efficiency and Equity: Changes in the Public Sector's Role*, documents that about one-half of those who are ill do not visit any health services and of those who do visit a health care provider, less than one-half use the extensive public health facilities. Utilization of public health facilities by the poor is very low.

The *Rand Health Expenditure Study* (1989-1993) finding that 70 cents of every dollar of total health expenditures were found to be out-of-pocket is indicative of effective consumer demand for service. Health care consumers are seeking convenience, privacy, efficiency and a perceived level of quality of health care services, including amenities, as well as access to technology and modern standards of medical practice. The emergence of worker protection laws and health insurance benefits has given further impetus to demand for private sector health services.

In the interest of improving efficient resource allocation and health sector performance, both public and private, the Ministry of Health (MOH) has taken important first steps to divest itself of long-standing financial obligations, such as guaranteed salaries for all medical doctors following their three-year public service commitment. Faced with shrinking public resources and evidence of consumers' willingness to pay for health services (across socioeconomic strata), the Government of Indonesia (GOI) will undoubtedly continue to divest itself of functional responsibility for health system operations, while retaining policy and oversight responsibility.

The MOH is poised to selectively focus efforts and limited fiscal resources on developing alternatives to current delivery arrangements and encouraging increasingly innovative, demand-sensitive responses to local health services needs - that means putting those who deliver services in the position of putting the consumer's interests first, in both public and private arenas. In this context, innovative business development and complementary policy-setting (especially in the arena of quality assurance) are key to the process of health sector reform.

III. THE INSURANCE ENVIRONMENT

The health insurance environment in Indonesia is evolving based on three distinct pieces of legislation, including Insurance Law #2 (governing commercial insurance), Health Care Assurance for Workers Law #3 (governing social insurance) and Health Law #23 (governing People's Health Maintenance Guarantee or JPKM). Each law specifies the legal status, requirements, obligations, regulatory guidance and supervision for its respective insurance program. For example, commercial insurance business, addressed in Law #2, is differentiated from social insurance. Social insurance is defined as compulsory by law (e.g., ASTEK[2] and ASKES[3] and JPKM[4] program benefits) and can only be conducted by a state-owned enterprise. Commercial insurance business may only be conducted by corporations in the form of: a shareholder company, a cooperative, a limited company or a mutual company. The Ministry of Finance requires and awards the operational permit for commercial insurance programs (an operational permit is not required for social insurance programs), yet enforces guidance and supervision for both commercial and social insurance programs. Social insurance programs are also accountable to the Ministries of Health, Manpower, Home Affairs and Public Works.

Despite the compulsory nature of ASTEK for private (limited liability) or state-owned enterprises, in practical terms the application of ASTEK requirements differs by size of firm. For example, large state-owned enterprises (notably ship-building, aircraft, oil, banking and land-based industries) that offer health benefits, or a health care delivery system that surpasses ASTEK basic requirements, are exempt from the requisite premium contribution (per employee) to the ASTEK fund. Small and medium-scale industries, therefore, comprise the principal contributors to the ASTEK fund (premium contribution is calculated at three percent of wages for single and six percent of wages for family). Of the 37 million paid employees in the formal economic sector in 1994, 7.8 million (only 21 percent of total eligible employees) were members of ASTEK. The *1994 Factbook on Employees Social Security* reports that young employees account for 70 percent of total members. The favorable composition of this risk pool is reflected in a benefits/claims or loss ratio of only 56 percent.

Eligible members of ASKES, which number more than 50 million government-sector persons, include current civil servants and military personnel, veterans and pensioners. Inclusion of the latter groups produces a higher claims ratio than that experienced by the

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[2] ASTEK implements the health program for those insured by private or state-owned enterprises. It offers both indemnity products as well as a basic benefits package, JPKM-program.

[3] ASKES implements the health program for those insured as government employees and for government agencies. ASKES offers multiple benefit packages including a JPKM-program.

[4] The JPKM program is a Basic Benefits Package offered through an implementing social insurance organization under regulation of the Director General of the Ministry of Health.

ASTEK program. According to the President Director of ASKES, claims account for 80 percent of contributions; administrative costs comprise 20 percent. Premium contribution is calculated as two percent of wages. Since 1993, ASKES has also offered voluntary enrollment in its program. More than 1,000 companies, representing 300,000 members, comprise private company participation.

The JPKM program includes the Basic Benefit Package as outlined below.

A. Ambulatory Outpatient Care
   1. Prevention
   2. Health Education
   3. Examinations, Treatment and Procedures
      a. Basic Immunizations
      b. Family Planning Services
      c. Maternal-Child Health Services, including Obstetrical Care Limited to Two Children
   4. Rehabilitation

B. Hospitalization Benefit of Five Days

C. Referral Care
   1. Diagnosis, Treatment and Medical Procedures
      a. X-rays and Ultrasonography
      b. Clinical Laboratory Diagnostics

D. Emergency Care

To date, JPKM implementing organizations include ASTEK-JPKM, ASKES-JPKM and DS-JPKM. The Director General of the Ministry of Health is responsible for the review and approval of: 1) proposed changes in the types, quantity or costs of delivering the Basic Benefit Package; 2) the capitation reimbursement of providers (currently Rupiah 1,380 for ASKES-JPKM); and 3) the determination of each implementing organization's reserve funds. Moreover, the Director General regulates and monitors the conduct of JPKM programs, both Basic as well as Increased Benefit Packages.

Private and pseudo-public organizations are poised to exploit the middle and upper income health insurance market segments. Based on experience of other developing economies, as well as Indonesia's own experience with large-scale industry insurance options, most types of insurance business should be successful in the upper end of the market.

There is an opportunity to achieve success with the low income market as well. Efficiency of provider network operations, measured by low unit costs, at an acceptable standard of quality, is essential to meeting the objective. Experienced and high quality management of administrative functions will assist the possibility of blending risk-pools to assure affordable care for all, which is the ultimate goal in the managed care system.

IV. THE KLATEN MANAGED CARE PILOT PROJECT

A tradition of pilot projects has served the GOI well. The Klaten managed care pilot project is one example. Pilot projects provide an opportunity to evaluate the practical implications of program principles and make mid-course corrections in their application. Furthermore, the cooperative spirit espoused in the 1992 Health Law guides the testing of solutions through the incremental adaptation of the affected sector.

During the period 1988 through 1995, the GOI, with assistance from USAID, instituted a number of fundamental health sector financing reforms intended to maximize scarce health sector resources. This set of reforms created a stable foundation from which to launch and test an integrated health system model designed to eventually serve all economic levels of Indonesia's communities, comprised of governmental entities that include 27 provinces, 3,400 districts and 66,000 villages, as well as non-governmental entities known as RW (with 15 community groups in each) and RT (a neighborhood association composed of 40 households). The principle of People's Health Maintenance Guarantee (JPKM) is at the core of this model and is defined as "a method of conducting health maintenance and care in a comprehensive fashion based on cooperative effort of all participants, with continuity and a guaranteed standard of quality, utilizing a pre-payment financing method." (Ministerial Regulation: Minister of Health, Number 527/Menkes/Per/VII/1993)

The integrated health system model was to incorporate all market segments, including the private sector-insured, government-insured, and the uninsured (including those in small enterprises, the self-employed and the unemployed). Implementing organizations would undertake the collection of premiums, contracting with a provider network, insuring service provision and administrative processes related to the management of the Health Maintenance Guarantee. To date, the implementing organizations have differentiated themselves by employer segment - those insured by private firms (ASTEK-JPKM), those insured by government (ASKES-JPKM) and the uninsured/underinsured (DS-JPKM). The JPKM option of ASTEK and ASKES insure workers and dependents. In contrast, DS-JPKM insures individuals for a monthly premium of Rupiah 1,500.

The Klaten pilot project, a microcosm of Indonesia's health sector, has initiated seven of the nine fundamental components of a managed care strategy whose ultimate purpose is to assure basic health protection for all market segments, including insurees of private and governmental organizations, as well as those who are uninsured or underinsured.

Critical reforms to the existing health care system are at the foundation of this trial and have contributed to greater stability in health sector performance. These reforms address improved efficiency of health facilities, improved allocation of expenditures, improved quality of medical practice through rationalization of drug use, specification of basic health benefits, and financial contribution of employers and consumers with the potential for broad-based blending of risk pools.

In its short history of operation, the Klaten pilot project, with test sites in the sub-districts of Trucuk (population 72,844), Ceper (59,365) and Delanggu (43,293), evidences the inevitable combination of a start-up program's strengths and weaknesses. Twelve percent market penetration in Klaten district, for the combined ASTEK, ASKES and DS-JPKM programs, has been achieved. The newest of the JPKM programs, DS-JPKM, has successfully conducted an initial marketing strategy using direct physician involvement.

Currently, each market segment is acting independently, thereby diluting their leverage. For example, the provider networks for each are unique with regard to service providers. The DS-JPKM network consists solely of public facilities (five health centers and one hospital). ASTEK-JPKM has contracts with nine private practice doctors, one private hospital, two dispensaries, a maternity center and an optical service. ASKES-JPKM has contracts with 34 health centers and a public hospital.

On the basis of an effectively tested foundation of health sector reforms, the GOI has an opportunity to achieve objectives of equity, efficiency and quality of their health care system for the population as a whole. The answer to "What is the proper mix between the public and private sector?" lies in experimentation that is guided by clear and unequivocal policy direction with regard to the non-negotiable objectives of the managed care strategy. The Klaten trial is demonstrating promise of success. Without an enhanced and more broadly-based implementation effort, the rapidly changing health sector environment may threaten the most critical elements of the strategy, specifically those that address the otherwise uninsured.

V. USE OF CREDIT TO FACILITATE HEALTH CARE FINANCING

Budgetary constraints at the national level have forced the GOI to reconsider the current formulation of health care provision. While the full implementation of the GOI's new health sector strategy is not complete, the Government has indicated that there will be a shift of a large number of health care service activities from the public sector to the private sector. If the private sector is expected to assume a much larger role in the management and provision of health care in Indonesia, many potential and existing private health care ventures will need to locate financing for their activities.

A. Micro and Small Enterprise Development Program

The Micro and Small Enterprise Development Program (MSED), managed by the Credit and Investment Staff of USAID's Center for Economic Growth, offers a Microenterprise and Small Business Loan Portfolio Guarantee. The MSED Program has been an effective tool for the promotion of economic growth in many countries.

As outlined in Exhibit 1, the MSED Program is designed to facilitate the mobilization of domestic credit for the development and expansion of micro and small enterprises. MSED provides a 50 percent guarantee on local currency loans from domestic financial institutions to micro and small enterprises; it thereby provides banks and borrowers with an alternative to excessive collateral requirements. Since there is an equal sharing of risk between USAID and each participating bank, the bank maintains an incentive to make a sound judgement of the borrower's ability to repay.

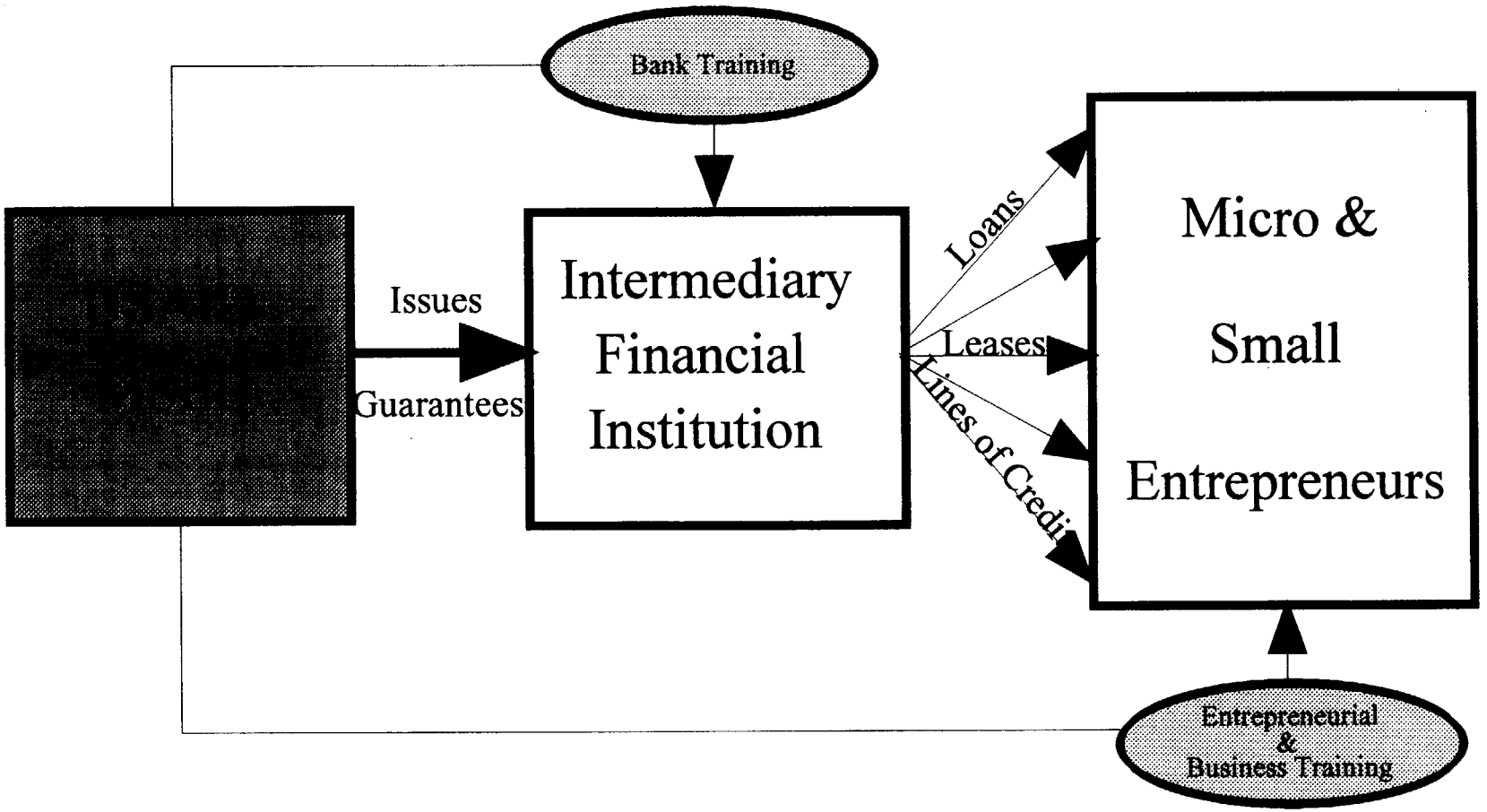
The expectation on the part of USAID is that, once banks which are relying on asset-based lending techniques realize that a potential borrower's lack of collateral does not necessarily indicate a lack of creditworthiness, they will see that thorough cash flow analysis is a more useful measurement of creditworthiness. Many banks' experiences with MSED-guaranteed loans which have been repaid in a timely manner have convinced them that, as prudent banking rules dictate, collateral should only be sought as a last resort, once prudent cash-flow and background analysis has been undertaken.

Local intermediary financial institutions (IFIs), such as commercial banks, insurance companies and leasing companies, are eligible to apply for MSED guarantee coverage. However, these institutions must meet certain criteria established by USAID to be eligible for an MSED guarantee facility. For example, participating financial institutions may only place loans to private sector borrowers under coverage. MSED also requires that the size of the private sector business receiving an MSED-guaranteed loan not exceed the local currency equivalent of US$250,000 in net fixed assets (excluding land and buildings). The maximum allowed loan amount to any one borrower is the local currency equivalent of US$150,000. The term of an MSED guarantee facility is normally five years, although this can be extended in certain cases.

MSED can be applied as a tool to enable existing or potential health sector participants to initiate or expand their access to commercial sources of credit. The standard five year MSED term appears to be a reasonable maturity ceiling for most health sector financing requirements. Many banks use the guarantee in situations where a new borrower with a sound business plan and other loan application requirements lacks the often large amount of tangible assets required as collateral by these banks. This alternative is particularly important for new borrowers because, while collateral requirements may be reduced or removed for previous or existing borrowers with good payment records, new borrowers are often required to pledge assets equivalent in value of as much as 200 percent of the amount of the loan.

Exhibit 1

STRUCTURE OF AN MSED GUARANTEE



V-7

The MSED guarantee program would need no special adjustment to include coverage of loans to health care providers in Klaten or anywhere else in Indonesia. Indonesian commercial banks are already among the most active users of the MSED guarantee. There are currently five Indonesian commercial banks participating in MSED: Bank Niaga; Bank Umum Nasional (two guarantee facilities); Pan Indonesia Bank; Bank Danahutama; and Bank NISP. Most of these banks have already made loans to health care providers in Jakarta and other cities. The participating banks with branches in Yogyakarta, Bank Niaga and Bank Umum Nasional, have indicated that health sector borrowers in Klaten could easily be serviced from their nearby branches.

It is important to note that Bank Niaga and Bank Umum Nasional are currently utilizing about 75 percent of their US$3 million MSED guarantee facilities, which have been in place for nearly five years. These banks expressed a willingness to initially use their existing guarantee facilities for health sector lending in Klaten. If new demand for these loans, combined with the financial institutions' normal loan growth and usage of MSED, increases the level of MSED utilization to nearly 100 percent, the opening of additional MSED facilities would be possible. The participating MSED banks, in coordination with USAID's Credit & Investment Staff, will continue to closely monitor the usage of the facilities to determine the types, amounts and maturities of loans placed under coverage. The data collected will be useful in tracking the level of health sector loans to the Klaten area.

B. Enhanced Credit Authority

The purpose of the Enhanced Credit Authority (ECA), as envisioned by USAID in the September 1994 Program Justification, is "to permit the use of market rate loans and guarantees to promote USAID's development priorities where they can be achieved with credit authority and where the risks can be reasonably estimated and managed." The successes achieved by the MSED Program were instrumental in the design work associated with ECA. One can think of ECA as a more flexible and adaptable version of MSED and, therefore, applicable across a broad spectrum of borrowers. In contrast to MSED, ECA is designed to offer loans and guarantees to both private and public sector borrowers. ECA could, for example, be used to provide a partial guarantee of a debt instrument issued to support a private or public sector development project. When and if ECA is available, its flexibility would allow it to play a vital role in the enhancement of the public infrastructure needed to improve critical health conditions throughout the country, i.e., improvement of water and sanitation facilities.

ECA is designed to share risk to the maximum extent possible. For non-sovereign projects, USAID will aim to take no more than 50 percent of the risk on any given credit transaction and, in no case will assume more than 80 percent of the risk. Only for long-term sovereign credit projects will USAID consider assuming 100 percent of the risk.

VI. POTENTIAL BENEFICIARIES OF THE USAID LOAN GUARANTEES

Credit enhancement mechanisms such as MSED and ECA would facilitate the access to credit for several participating groups involved in the provision of health care services. Although it is not entirely clear whether certain health care providers will emerge from the coming changes as public or private sector entities, the consultant team has identified the following groups as the most likely to benefit from MSED: ambulatory service practitioners, including physicians, midwives and paramedics; private hospitals; free-standing ambulatory facilities, e.g., diagnostic or day surgery; and entities providing management or administrative services.

A. Micro and Small Enterprise Development Program

Ambulatory Service Practitioners and Facilities. Doctors are one type of ambulatory service provider. Doctors completing their three-year government service (in exchange for a government-financed medical education) were, until recently, assured by the government that they would be guaranteed a position in a government medical facility. The Government recently stated that, in the absence of open positions at public (i.e., government-owned) hospitals, such "contract doctors" will be faced with a choice of creating or joining an existing practice in the private sector.

While doctors and other health care professionals (paramedics, midwives, etc.) would seem to be attractive clients for banks and other financial institutions because of their earning potential, they face many of the same obstacles that most new borrowers experience, including high collateral requirements. Several contract doctors interviewed described their intentions to establish a group practice of four or five doctors. Each group practice would most likely sign a contract with a JPKM to provide services but would need some financial assistance to start their practice. Doctors would most likely be borrowing to finance general start-up costs, such as: modernizing or renovating office space; basic furniture; and supplies. Initially, they would not need to purchase sophisticated or expensive radiology or laboratory equipment, since access to such equipment would be assured by contracting with local hospitals.

The MSED guarantee would encourage participating MSED banks to lower their collateral requirements for loans to these group practices. The financing needs anticipated by the doctors interviewed fall well within the maximum loan amounts allowed under MSED. One doctor estimated start-up costs of approximately Rupiah 60 million (US$27,0000) over a three month period.

Private Hospitals. While government-owned hospitals are not eligible for MSED-guaranteed loans by Indonesian banks, private sector hospitals are eligible and would likely seek financing for medical equipment, upgrading of facilities and related activities. Some private hospitals may have a strong enough financial statement to enable them to obtain bank financing with little or no collateral requirements. Other private hospitals

may have sufficient amounts of assets available to pledge as collateral for loans. These hospitals would not need an MSED-guaranteed loan. The private hospitals seeking MSED-guaranteed loans will most likely be those small hospitals which need to purchase medical equipment or are expanding service capabilities, yet lack the amount of collateral required by most banks.

The GOI recently introduced environmental regulations pertaining to the proper disposal of hospital waste by hospitals. Hospitals will need to purchase various types of environmental equipment to enable them to comply with the new regulations. The equipment can be quite expensive, with some treatment systems costing as much as Rupiah 1 billion (US$455,000). Most hospitals will need to obtain financing from local financial institutions but may be constrained by a lack of collateral. Financial institutions participating in the MSED Program may be able to offer financing for some of the environmental equipment purchases, substituting the MSED guarantee for a portion of the collateral requirement.

Management/Administrative Entities. At present, public hospital employees, organized as cooperatives, provide a limited set of business functions to their employing hospital on a contingent basis. Such functions have included cleaning services, drug store, canteen and catering services. Loan guarantees for the development and/or expansion of additional business functions performed and managed by cooperatives is an opportunity. These cooperatives could be spun-off as separate and, more importantly, private sector entities. Similar vehicles may be applicable to other public management entities, such as administrative activities of JPKMs.

Private Sector Financial Institutions. In addition to the ability to share credit risk with USAID, financial institutions participating in the MSED Program are offered two-week training workshops on an annual basis. Since many financial institutions currently employ asset-based lending techniques, which generally leads to exceptionally high collateral requirements, the training concentrates on cash flow lending techniques for loan and credit officers. Financial institutions which have participated in this training have witnessed the benefits of reducing collateral requirements for potential borrowers demonstrating a cash flow level sufficient for timely loan repayment. The participating financial institutions can also recommend several potential or existing borrowers for business skills training in areas such as business plan preparation, bookkeeping and bank relations.

B. Enhanced Credit Authority

Although the availability of ECA is uncertain, it is worth considering how it could be used in Indonesia. Shortly after ECA's possible availability was announced by USAID/Washington to USAID missions around the world, USAID/Jakarta began exploring the possibility of using ECA to facilitate the issuance of municipal revenue bonds by a local water authority. By offering a partial ECA guarantee, USAID would

share 50 percent of the risk with the local banks issuing the bonds on behalf of the water authority, enabling the water authority to borrow funds at a reasonable cost and for a maturity exceeding those of existing debt securities in the market. Since it recently became obvious that ECA would not be available in time for the anticipated July 1996 issuance of the bonds, it was decided that the bonds would be issued as scheduled, carrying only a guarantee of the issuing banks. The absence of the ECA guarantee will add one or two percentage points to the cost of the bonds, because investors will demand a higher return to compensate for the higher level of perceived risk.

This case demonstrates how ECA, when and if it is available, could be used to support health, environmental, urban infrastructure and other development activities. In the health sector, for example, there is progress being made in Indonesia regarding the creation of *swadana*, which are self-financing units within hospitals. *Swadana* is designed to enable hospitals to become more responsive health providers. The units perform clinical and other services for the hospitals, charging fees and using the funds to purchase supplies and other needs. While it has not yet reached the point where these units are considered completely separate entities, they are legally segregated from the hospital for accounting and fund management purposes. This is similar to the distinction in Indonesia between state-owned enterprises[5] and government agencies. ECA could possibly be used to facilitate the spin-off of some of these units as separate private sector entities.

Another possible use of ECA involves USAID/Jakarta's expectation that the current Klaten district government-owned enterprise DS-JPKM will be replaced with a JPKM corporation. An ECA guarantee could be used to facilitate the privatization of the complete DS-JPKM. An MSED guarantee, on the other hand, could be used to privatize specific functions (i.e., marketing, utilization management) of a JPKM implementing organization. The potential for privatization, which is outlined in Exhibit 2, will require further assessment to determine the readiness of each entity.

VII. OUTSTANDING ISSUES

A. Fiscal Soundness of JPKM Program

Several aspects of the managed care strategy are in the earliest stages of implementation, and thus require experience, management development and investment to fine-tune their performance. Experimentation with the earliest forms of marketing, for example, have had difficulty balancing the need for cultural sensitivity with the need for rapid market penetration in order to assure fiscal soundness. The positive response and performance

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[5] Off-budget entities, such as Garuda Airlines and Pertamina Oil, which are expected to be self-financing and operate without government subsidies.

Exhibit 2: Focus for USAID Loan Guarantee and Other Financing Mechanisms *

A. Innovative Business Development

Process	Function	Potential for Privatization	MSED	IESC	ECA	Grant
JPKM Implementor	All Functions	Very Good			X	X
	Marketing/Sales	Fair	X	X		
	MIS Development	Very Good	X			
	Utilization Management	Very Good	X			
	Network Operation	Poor				
	Claims Administration	Very Good	X			
Health Services	Primary Care Offices	Very Good	X			
	Outpatient Diagnosis	Very Good	X			
	Inpatient Services	Fair			X	
	Home Care Services	Very Good	X			
	Rehabilitation and Therapies	Very Good	X			
	Day Surgery	Very Good	X			
	Medical Waste	Very Good	X			

Feasibility of using Credit to Support Managed Care Pilot Project

* A conservative use of available financing mechanisms is assumed in the choices noted.

Exhibit 2: Focus for USAID Loan Guarantee and Other Financing Mechanisms

A. Innovative Business Development (Continued)

Process	Function	Potential for Privatization	MSED	IESC	ECA	Grant
Health Infrastructure	Water Supply	Poor			X	
	Sanitation Systems	Poor			X	
	Occupational Safety	Very Good	X			
	Workers Compensation	Very Good	X			
B. Policy Development						
Manpower Development & Training		Fair	X	X		
Licensure and Accreditation of Providers		Partial	X		X	

Feasibility of Using Credit to Support Managed Care Pilot Project

of the Klaten district with regard to early experimentation, however, suggests that the time is ripe for more bold approaches to implementation. There are, however, several questions regarding JPKM that need to be addressed:

What is the monitoring and correction strategy regarding projections for marketing, utilization and administrative costs for JPKM programs? Are private facilities precluded from participating in the DS-JPKM network, and would a combination of public and private facilities contribute to reduced unit costs of services? Will public facilities assume full responsibility for their complete unit costs, including staff salaries? Does the DS-JPKM have adequately prepared management, trained in managed care strategies and experienced in contract negotiation? Are there incentives for the development of alternative, cost-effective service options such as home care or day surgery programs?

B. Framework for Blending Risk Pools

Important risks and opportunities exist with regard to the viability of the managed care strategy. Within the broader health sector environment, private and pseudo-public organizations are poised to exploit the middle and upper income market segments. If the GOI is to achieve its objective of blending risk pools across market segments, targeted and unequivocal policy direction setting is essential in order to establish the framework, boundaries, obligations and constraints within which all participants are expected to perform. Several questions relating to the blending of risk pools need to be addressed:

Is there a clear mechanism for system-level blending of risk pools across market segments? What is the appropriate size population base for blending risk pools? How has the mechanism of coordination of benefits been implemented with the Klaten pilot project? Will the current assumption of three percent of average GDP per capita for the DS-JPKM premium require substantial downward adjustment in order to encourage as broad participation as possible?

C. Business Development Skills

Private hospitals can demonstrate their administrative, management, accounting and other skills to prospective lenders. In contrast, most of the financial institutions visited indicated that newly-established ambulatory service providers sometimes lack not only adequate collateral, but also some essential business management skills such as: office management; bookkeeping; accounting; finance; and marketing. While, for example, the financial institutions indicated that participation in MSED would allow them to reduce the standard collateral requirement, the business management skill level of the borrower and the quality of the business plan will be key determining factors in the loan decision. They inquired about the possibility of these potential borrowers receiving business management skills training in connection with loans.

While MSED has some short-term training services associated with its guarantee facilities, the health sector borrowers seeking commercial sources of financing would likely need more specific and in-depth training. USAID/Jakarta has access to funds for some training activities through the International Executive Service Corps (IESC) program. Several questions relating to the demand for, and marketing of, these services need to be addressed:

Are the health care providers prepared to be entrepreneurs? Is there sufficient interest in services and functions that could be privatized? How will health care providers learn about MSED and training? How will interest be stimulated in the project and MSED?

D. Role of the Government

The proper role of the government in the health sector is evolving and is complicated by the competing and/or overlapping interests, responsibilities and policies of several Ministries, including Health, Finance, Manpower, Cooperatives, and Internal Affairs. A forum that creates an environment for harmonizing policy, encouraging national leadership in securing basic protections and advancing the strengths of private sector efficiency, as well as the commitment to public equity, is critical to the success of the managed care strategy. Since all sectors will benefit from efficiency and cost-containment gains, as well as quality improvement aspects of managed care, such collaboration and leadership is a shared self-interest. Several important questions relating to the proper role of the GOI in health sector development need to be considered:

What are the potential forums within which to harmonize the overlapping interests of relevant Ministries? What party might convene a collaborative body? Is it necessary that the GOI maintain some level of health sector facility ownership? How can the substantive health effects of investments in maternal education, sanitation and sewage infrastructure be incorporated in the policies of the MOH?

VIII. SUMMARY

On the basis of an effectively tested foundation of health sector reforms, the GOI has an opportunity to achieve objectives of equity, efficiency and quality of their health care system for the population as a whole. The answer to "What is the proper mix between the public and private sector?" lies in experimentation that is guided by clear and unequivocal policy direction with regard to the non-negotiable objectives of the managed care strategy. The Klaten trial is demonstrating promise of success. Without an enhanced and more broadly-based implementation effort, the rapidly changing health sector environment may threaten the most critical elements of the strategy, specifically those that address the otherwise uninsured. In this context, innovative business development and complementary policy-setting (especially in the arena of quality assurance) are key to the process of health sector reform.

With regard to innovative business development, this consultancy has explored a variety of legal vehicles that are available and relevant to advancing the strategy of managed care. With regard to policy-setting, the newly effective World Bank Health Project IV, which focuses on improving quality of care, converges with USAID's support for innovative business development and presents a unique opportunity for the GOI to gain multiplicative effects by synchronizing the investments of both.